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Nathalie J. Rodríguez
Resilient Open Heart: An
Exploration of Compassion Fatigue,
Compassion Satisfaction, and
Spiritual Practice with End of Life
and Palliative Care Clinicians

ABSTRACT

This quantitative study sought to explore how participation in spiritual practice related to self-reported levels of compassion fatigue and compassion satisfaction amongst a sample of 55 mental health clinicians in the end of life and palliative care field (EOLPC). The study used an online questionnaire to assess for levels and types of participation in spiritual practice. Additionally, the study utilized the Professional Quality of Life Scale Version V to measure compassion fatigue, compassion satisfaction, and burnout. The findings of this study demonstrated that participants had lower than average levels of compassion fatigue and burnout. Participant levels of compassion satisfaction were moderate and within average ranges. The majority of the sample identified as participating in various forms of frequent spiritual practice. Participants found that these forms of spiritual practice supported their EOLPC clinical work. The findings from this study indicate a need for further research to examine additional factors that may support EOLPC mental health clinicians to thrive in their professional and personal lives.

**RESILIENT OPEN HEART: AN EXPLORATION OF COMPASSION FATIGUE,
COMPASSION SATISFACTION, AND SPIRITUAL PRACTICE WITH END OF LIFE
AND PALLIATIVE CARE CLINICIANS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Nathalie J. Rodríguez

Smith College School for Social Work
Northampton, MA 01063

2016

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I dedicate the merit of this thesis to all of the patients who taught me how precious and necessary it is to bring my whole heart to this work.

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PREFACE

Some of you say, “Joy is greater than sorrow,” and others say, “Nay, sorrow is the greater.” But I say unto you, they are inseparable. Together they come, and when one sits alone with you at your board, remember that the other is asleep upon your bed. Verily you are suspended like scales between your sorrow and your joy. Only when you are empty are you at standstill and balanced.

—Khalil Gibran, *The Prophet*, 2011

Gibran’s prophetic poetry suggests that sorrow and joy are like conjoined twins that breathe from the same source. Facing catastrophic illness and death, both personally and professionally, has shaped my relationship with these twin emotions. Some of the most profound moments of joy in my life have arisen in rooms where suffering was present. The intimate work of engaging with death and illness has also invited me to touch what I have come to understand lies at the base of the twin scale of joy and sorrow, love. Without an open heart, love cannot arise.

In the beginning of my work as a novice hospice volunteer it felt natural to align with the sorrowful aspects of my dying patients’ experiences. My ability to feel their pain and tolerate intense affective states convinced me that I was engaging with my true vocation of “being with dying” (Halifax, 2008). It took me a few months to notice all the ways that my naiveté and unskillful means of navigating the suffering around me had negatively impacted my own life. I became acutely aware of my feelings of exhaustion, insomnia, and patterns of disengagement

with dying patients. Additionally, my capacity to experience and share joy with my loved ones had diminished.

The depth of my own suffering led me to investigate how spiritual practices (ritual, meditation, contemplative prayer, and yoga) could support me to embrace sorrow and joy equally. My practice of turning inward showed me all the ways that I had misunderstood my role and what it truly meant to be compassionate and empathic with the dying people I sat with. I began to learn my limits, ways to renew myself, and what it truly meant to intimately engage with the great matter of life and death from a “strong back, soft front”(Halifax, 2008, p. 14). My experience as a medical social work intern on a palliative care team this year opened up a new chapter of my *camino* (journey) of investigation.

This chapter of my *camino* invited me to explore how the fields of clinical social work, traumatology, theology, and neuroscience conceptualized the balanced scale of sorrow and joy that Gibran (2011) illustrated. This thesis project was my attempt to understand the relationship between sorrow and joy as it is conceptualized in the constructs of *compassion fatigue* and *compassion satisfaction*. More than anything else, I wanted to understand how participation in spiritual practice impacted others that were working intimately with illness and death. The question beneath my research has remained: what allows clinicians in the end of life and palliative care field to engage in their work from an open and resilient heart?

CHAPTER I

Introduction

Compassion, derived from the Latin roots *pati* and *cum*, literally means “to suffer with.” Most modern understandings of compassion have moved past the early root definition to include a component of skillful engagement. Thus, compassion can be understood as the act of empathically connecting to someone else’s suffering and engaging in some form of action to alleviate that suffering (Hollingsworth, 2008). Compassion is a vital ingredient for clinical practice with clients facing the vulnerability and suffering that most often accompanies illness and death. Many clinicians that enter the end of life and palliative care (EOLPC) field have a deep commitment and calling to compassionately support clients in transforming their own suffering. This commitment to serve patients facing death and illness invites EOLPC clinicians to face some of life's most intimate and challenging moments.

Traumatology research has shown that mental health clinicians engaged in the work of caring for individuals experiencing physical and emotional trauma are also at risk for developing trauma symptomology (Figley, 1995, 2002.) Figley (1995) first introduced the term *compassion fatigue* to describe the range of adverse reactions that helping professionals experienced as a result of working with suffering individuals. Figley (1995) asserted, “The professional work centered on the relief of the emotional suffering of clients automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering itself as well” (p. 2).

The term *compassion satisfaction*, emerged later in traumatology literature to describe the degree of joy and fulfillment that clinicians experienced in their work with traumatized individuals (Stamm, 2010). Researchers have suggested that the delicate balance between compassion satisfaction and compassion fatigue is what determines a clinician's ability to thrive in their professional role (Kapoulitsas & Corcoran, 2015; Sprang, Clark, and Whitt-Woosley, 2007; Gregory, 2015, Decker, Brown, Ong, & Stiney-Ziskind, 2015). The majority of research conducted on compassion fatigue and compassion satisfaction has examined these constructs in the context of crisis and disaster, domestic violence, sexual violence, health care, and traumatic bereavement. However, research has focused very little on the professional experiences unique to mental health clinicians working in the EOLPC field.

Clinicians working in the EOLPC field are often at the frontlines of addressing the emotional, physical, and spiritual pain related to catastrophic illness, invasive medical interventions, and sudden loss. Self-care has been discussed in the fields of social work, medicine, and psychology as an antidote to the occupational challenges faced by EOLPC clinicians. Spirituality and participation in spiritual practice has been cited as an important component of self-care for clinicians who work intimately with suffering and trauma (Cunningham, 2004). Unfortunately, few studies have examined the impact of participation in spiritual practice for EOLPC clinicians.

The purpose of this study was to explore the following research question: how is participation in spiritual practice related to self-reported levels of compassion fatigue and compassion satisfaction among mental health clinicians working with clients receiving end of life and/or palliative care? This study also intended to examine the prevalence of compassion fatigue/compassion satisfaction amongst a sample of mental health clinicians engaged in the

EOLPC field. Lastly, the study sought to explore if and how participation in spiritual practice supported the work of clinicians in the EOLPC field.

The following chapter presents and explores the research that has been conducted on compassion fatigue/compassion satisfaction theory, occupational vulnerabilities for EOLPC clinicians, and spiritual practice as a protective factor. The methodology chapter describes the nature of the study design, data collection, and the study's limitations. The findings chapter presents the relevant data findings from the study and patterns of qualitative responses from study participants. Finally, the discussion chapter weaves together the themes found in the participant responses with the existing body of research in compassion fatigue, compassion satisfaction, and the experiences of end of life/palliative care clinicians.

CHAPTER II

Literature Review

Introduction

The purpose of this study was to understand how participation in spiritual practice related to compassion fatigue and compassion satisfaction reporting in mental health clinicians working in the end of life and palliative care field. Additionally, the study sought to explore if and how participation in spiritual practice functioned as a protective factor against compassion fatigue for clinicians. Literature will be reviewed in the following categories to create a framework for this study: 1) compassion fatigue theory; 2) compassion satisfaction theory; 3) occupational vulnerabilities specific to palliative and end of life care clinical work; 4) spiritual practice as a protective factor against compassion fatigue.

Compassion Fatigue Theory

There has been considerable research conducted to understand the detrimental impacts of serving individuals who have experienced trauma. Researchers have used the terms burnout (BO), vicarious trauma (VT), and compassion fatigue (CF)/secondary traumatic stress (STS) to differentiate the constellations of stress symptoms reported by professionals who work closely with human suffering and trauma. Subsequently, the term compassion satisfaction (CS) was constructed to measure the benefits and positive emotions associated with working in the helping professions (Stamm, 2002). Killian (2008) summarized the subtle differences between the three main constructs (BO, CF, CS):

If one were to attribute affective domains to the three constructs, one could say that compassion fatigue dwells in the neighborhood of fear and anxiety, compassion satisfaction in pleasure or happiness, and burnout in emotional exhaustion and lack of self-efficacy (p. 33).

Acknowledging the obvious similarities and subtle differences of these terms is relevant to understanding the etiology of compassion fatigue and the factors that may account for its prevalence amongst clinicians in the end of life/palliative care (EOLPC) field. The following sections of this literature review will examine the aforementioned constructs to clearly define compassion fatigue, identify risk and protective factors for CF, and outline factors that support CS.

Burnout. Burnout (BO) is a term that has been adopted into our mainstream lexicon to describe a variety of stress symptoms related to professional and occupational factors. Despite its commonplace usage, the condition of burnout has been empirically studied to assess how certain occupational hazards, such as large caseloads and exposure to trauma, can impact an array of professionals. Numerous qualitative and quantitative studies with hospice and palliative care clinicians have identified that the stress of working with patients experiencing terminal illness and death is correlated with high levels of burnout in the field (Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013; Quinn-Lee, L., Olson-McBride, L., & Unterberger, 2014).

Maslach (1982) defined burnout as having *three principal dimensions*: emotional exhaustion, depersonalization of others, and a feeling of reduced personal achievement (as cited in Lee & Ashforth, 1990, p. 743). A participant in Killian's (2008) mixed-method study of burnout with 124 mental health clinicians described feelings of burnout that mirror Maslach's three dimensions:

I think I get overwhelmed, and overwhelmed for me comes in two forms: I get physically, emotionally and mentally exhausted, and I also become emotionally shutdown and I am not as emotionally responsive to people. I feel like I don't have any more to give, it is all used up and gone (p. 35).

Maslach's three dimensions of burnout overlap to some extent with affective categories present in the aforementioned constructs (VT, CF). However, research on burnout has focused on the specific impacts that stressful and demanding work environments have on a professional's experience, effectiveness, and wellbeing (Figley, 1997). The literature has distinguished burnout as a condition that builds over time and arises from a particular type of reactive stress to the work environment and systemic conditions (Murphy, 2014).

Institutional and professional environmental factors such as lack of supervision, high volume caseloads, long workdays, and low wages are associated with burnout more than VT and CF (Sprang, Clark, & Whitt-Woosley, 2007). Thus, institutional level interventions are necessary to alleviate burnout symptomatology amongst professionals working with trauma survivors (Killian, 2008). Self-care strategies, such as exercise, spirituality, increased socialization/leisure activity, and adequate sleep, have been cited throughout empirical studies as protective factors against burnout (Killian, 2008; Quinn-Lee, Olson-McBride, & Unterberger, 2014; Harrison & Westwood, 2009). Research has shown that these protective factors and coping strategies are also effective in addressing vicarious traumatization and compassion fatigue (Sprang et al., 2007; Figley, 2002; Cunningham, 2004).

Vicarious Traumatization. Unlike burnout, the term vicarious traumatization (VT) is directly associated with a clinician's reaction to the traumatic material they are exposed to in their work (Figley, 2002). The client's trauma material, rather than institutional and

environmental factors, is at the root of vicarious traumatization symptomology. McCann and Pearlman (1990) first identified this theoretical construct in an effort to understand how psychotherapists were being impacted by their work with trauma survivors over time. VT theory seeks to explain why negative changes in a clinician's psychological, emotional, and physical wellbeing often mirror their client's trauma symptoms (Harrison & Westwood, 2009).

Trauma is discussed throughout the VT literature as an experience or series of experiences that can disrupt a clinician's positive psychological schemas (cognitive manifestations of psychological needs) and reinforce negative schemas (Pearlman & Saakvitne, 1995; Cunningham, 2004). Thus, VT is conceptualized as a cumulative and inevitable process that produces negative changes in a therapist's cognitive schemas and overall internal experience (Cunningham, 2003). Some theorists have argued that these changes in a clinician's personal and professional life are the permanent consequence of working intimately with suffering (Pearlman & Saakvitne, 1995, p. 151).

Later research (Pearlman & Saakvitne, 1995; Harrison & Westwood, 2009) differentiated VT from classical psychodynamic understandings of therapist countertransference. Countertransference refers to the unavoidable reactive process that takes place within a clinician as a result of being engaged in a relational process with their clients. This phenomena arises from a clinician's own unresolved experiences, unconscious material, and trauma experiences (Harrison & Westwood, 2009). The literature has often conflated VT and countertransference, despite the fact that VT stems from a clinician's exposure to external traumatic material provided by their client. Compassion fatigue has been similarly conflated with countertransference and vicarious traumatization (Figley, 2002).

In their qualitative study of six experienced psychotherapists working with traumatized clients, Harrison and Westwood (2009) found that empathic engagement served as a protective factor against VT. Their research illustrated that clinicians who practiced *exquisite empathy*, “a discerning, highly present, sensitively attuned, well-boundaried, heartfelt form of empathic engagement,” experienced nourishment and fulfillment from their interactions with traumatized clients (Harrison & Westwood, 2009, p. 213). Literature on vicarious traumatization and compassion fatigue has traditionally cited empathy as a central risk factor for the development of stress and trauma symptoms (Figley, 1997; Valent, 2002). Harrison and Westwood’s (2009) contribution offers a new framework for understanding how different types of empathic engagement can impact clinicians facing VT and CF.

Compassion Fatigue. Similarly to vicarious traumatization, compassion fatigue is defined as an inevitable consequence of working with individuals who have experienced trauma. The term was first used in nursing to describe an array of emotional, behavioral, and psychological changes that nurses were experiencing as a result of their work with suffering patients (Joinson, 1992). Early constructs of CF asserted that exposure to a patient’s physical and emotional suffering had a marked negative impact on a healthcare provider’s own personal and professional experience. Although the initial literature on CF did not specifically focus on trauma, it created a pathway for understanding the relational impact that working closely with suffering patients had on a healthcare provider. Later studies on CF prevalence with oncology and hospice nurses helped broaden the definition of trauma to include terminal/life threatening illness and invasive medical interventions (Najjar, Davis, Beck-Coon, Doebbeling, & Carney 2009; Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris, & Olsen, 2010).

Figley (1995) promoted the term compassion fatigue in traumatology research as a more “user friendly” alternative to the term secondary traumatic stress disorder (as cited in Figley, 2002, p. 4). The term secondary traumatic stress (STS) disorder encompasses symptomology that is nearly identical to the American Psychiatric Association's DSM-V criteria for posttraumatic stress disorder (PTSD) (American Psychiatric Association, 2013). STS/CF and PTSD have one main difference: PTSD manifests when an individual experiences trauma themselves while STS/CF manifests when an individual witnesses or hears about another's trauma (Figley, 2002). Despite some conflicting opinions found in the literature, it is generally accepted that compassion fatigue has an acute onset following exposure to traumatic material (Murphy, 2014; Figley 2002). Cumulative compassion fatigue symptoms can lead clinicians to experience burnout if they are not treated in a timely fashion (Figley, 2002).

Figley (2002) outlined the following STS/CF symptoms: recurrent and intrusive distressing recollections of client/event, intense psychological distress at exposure of internal or external cues that symbolize or resemble work of helping others, physiological reactivity, avoidance of activities/thoughts/feelings/ that symbolize a client's trauma, errors in professional judgment about treatment, depression, anxiety, feelings of emotional detachment, hyper vigilance, sleep disturbance, difficulty concentrating, emotional reactivity, and exaggerated startle response (p. 4-5). Many of the aforementioned compassion fatigue symptoms overlap with burnout and vicarious traumatization symptoms discussed in the reviewed literature (McCann & Pearlman, 1990; Valent 2002; Killian 2008; Cunningham 2003; Pearlman & Saakvitne, 1995).

Empirical studies and theoretical literature on the etiology of CF cite a number of risk factors. Some of the risk factors cited include: female gender, younger age, larger caseloads, personal history of trauma, rural setting, higher number of direct practice hours with traumatized

clients, higher caseloads with traumatized clients, pathogenic work environments, lower levels of supervision/professional support (Sprang et al., 2007; Kapoulitsas & Corcoran, 2015). Numerous quantitative and qualitative studies have shown that increased trauma education, social support, self-awareness, stress management practices, self-care practices (including spirituality), and supervision can act as protective factors against CF (Sprang et al., 2007; Sansó, Oliver, Pascual, Sinclair, & Benito, 2015; Figley, 2002; Gregory, 2015).

Figley introduced the earliest version of the etiological model of CF in 1995 (Figley, 1995; Figley 2002). This model outlined ten variables that predict CF; empathic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollections, and life disruptions (Figley, 2002). Figley's model contains only two variables (sense of achievement and emotional disengagement) that his theory asserts are effective in lowering levels of compassion stress that lead to CF. The other eight variables, such as empathic concern and empathic response, are correlated with higher levels of compassion stress and probable CF (Figley, 2002).

Consequently, the etiological model of CF is based on the assumption that “without empathy there will be little to no compassion stress and no compassion fatigue” (Figley, 2002, p. 1436). Most of the reviewed CF literature has been influenced by this foundational assumption about empathy being the culprit of CF. There have been few empirical studies focused on CF specifically that have challenged this assumption or offered a different perspective. Further research is needed to understand the psychological, spiritual, and neurobiological dimensions of empathy as they relate to CF symptomatology. For now, alternative understandings of empathy, such as Harrison and Westwood's (2009) “exquisite empathy” have not translated into further empirical research studies or frameworks for education and training.

Additions to the traditional compassion fatigue theory have come from the fields of neuroscience and traumatology (Valent, 2002; Rushton, Kasniak & Halifax, 2013; Hollingsworth, 2008; Tone & Tully, 2014). One salient theory used a “wholist perspective” to conceptualize the biopsychosocial causes that are at the heart of CF (Figley, 2002). Valent (2002) suggested that CF arises when the particular survival strategy, "Rescuing/Caretaking," is ineffective in mitigating the professional helper's stress that is triggered by a client's trauma. Adaptive aspects of this strategy are associated with the psychological and social responses of caretaking, empathy, devotion, and nurturance. The Rescuing/Caretaking survival strategy, when functioning adaptively, was found to produce the immune boosting and joy enhancing hormone oxytocin (Valent, 2002, p. 22). This neurobiological function accounted for feelings of fulfillment and connection in the face of high stress and trauma exposure.

Maladaptive aspects of the Rescuing/Caretaking strategy were associated with the psychological and social responses of burden, depletion, self-concern (about safety and effectiveness), resentment, neglect, and rejection (Valent, 2002, p. 23). Valent's (2002) framework offers a different understanding of what is occurring on a unique neurobiological, social, and psychological level when professional helpers encounter trauma and attempt to address their compassion stress. Valent's (2002) CF theory is consistent with vicarious traumatization theory, which asserts that client trauma exposure can have a negative impact on a clinician's cognitive schemas.

Tehrani's (2007) research focused more closely on the connection between CF and changes in a clinician's assumptions, values, and beliefs (cognitive schemas). The researcher's quantitative study surveyed 430 care workers who were regularly exposed to secondary trauma and high levels of distress in their professional work. Results from the study showed a high

prevalence (over 60%) of professionals experienced some negative changes in their beliefs about the world (Tehrani, 2007). This finding is consistent with many other studies on the prevalence of CF amongst mental health workers. Tehrani's (2007) study additionally found that 79-92% of professionals working with traumatized individuals identified with positive beliefs about their caring work. Spiritual and religious practices were cited as protective factors for care workers in this study.

The aforementioned literature outlined numerous ways that professional caregiving and clinical work can have a negative impact on providers. However, some of the same literature cited examples of how professional caregiving and clinical work can positively impact care providers when they have particular types of professional and personal support in place. Compassion satisfaction is the last theoretical construct of interest in this literature review. The following section explores why and how some clinicians and care providers are able to thrive in the face of the suffering they encounter on a daily basis.

Compassion Satisfaction. Compassion fatigue research has demonstrated that clinicians may experience feelings of fulfillment in the face of CF and BO. The term compassion satisfaction was constructed in an attempt to explore the beneficial aspects of clinical work with individuals who have experienced trauma (Stamm, 2002). Additionally, the term relates to feelings of joy and pleasure that a professional may feel as a result of their helping role with others. Research studies that have focused concurrently on compassion satisfaction and compassion fatigue have shown that the two constructs often exist in a delicate balance (Kapoulitsas & Corcoran, 2015; Sprang et al., 2007; Gregory, 2015; Decker, Brown, Ong, & Stiney-Ziskind, 2015). A clinician may rate equally high on CF measures as they do on CS measures, but not experience the detrimental effects of CF. Stamm (2002) has argued that this

delicate balance is what allows many clinicians to thrive in their professional roles in the face of many internal and external risk factors.

Radey and Figley (2007) introduced a model of compassion satisfaction with the intention to shift the focus of CF research towards examining clinicians' feelings of fulfillment and wellbeing. Their model incorporated aspects of positive psychology and the holistic social work perspective (Radey & Figley, 2007). Affect, work resources, and self-care were cited as the main factors that impact a clinician's fulfillment/distress ratio. Radey and Figley (2007) asserted that positive affect (feelings of gratitude/appreciation/liking) provided clinicians with innovative ways of intervening with clients. Negative affect was associated with a restricted ability to intervene in new and creative ways and an overall diminishing effect on a clinician's ability to help their clients (Radey & Figley, 2007, p. 209).

Self-care has been mentioned throughout the literature on compassion fatigue, burnout, vicarious traumatization, and compassion satisfaction. Radey and Figley (2007) defined self-care as "a potential mechanism to increase clinicians' positive affect and physical, intellectual, and social resources" (p. 210). Self-care activities often fall into two categories, individual self-care and organizational self-care. Individual self-care encompasses activities such as exercise, spiritual practice, socializing, personal psychotherapy, and taking time off from work.

Organizational self-care corresponds with the ways that an organization supports clinicians and facilitates opportunities for them to practice self-care (Radey & Figley, 2007). Examples of organizational self-care cited in the literature are providing adequate supervision, staff training opportunities, adequate financial compensation, and assigning appropriate caseloads. Creating agency cultures that prioritize self-care could contribute to increased compassion satisfaction and success for clinical social workers (Radey & Figley, 2007).

Compassion satisfaction and self-care are not topics that have been incorporated into many graduate level educational programs, particularly not in the medical field. Many clinicians entering medical social work, where they will be faced with high levels of medical crisis and types of trauma that are infrequently framed as such, have not been taught how to foster CS. A quantitative exploratory study by Simon, Pryce, Roff, and Klemmack (2006) examined compassion fatigue, burnout, and compassion satisfaction amongst 21 oncology social workers. Simon et al., (2006) used the Compassion Fatigue and Satisfaction Self-Test, an earlier iteration of the Professional Quality of Life Scale (ProQOL), to measure stress related constructs. The study found that oncology social workers experienced CF and BO, and that both CF and BO were inversely related to CS. This finding suggests that symptoms of BO and CF may play an important role in levels of professional fulfillment and personal gratification amongst oncology social workers. The results from this study about CS/BO highlight the importance of differentiating between the symptoms of each work related stress construct. Clinicians must first be aware of their CF, VT, and BO symptoms before they can heal from CF/BO and increase their feelings of compassion satisfaction.

Simon et al. (2006) found that the lowest CS scores were reported by oncology social workers with the highest levels of licensure. The tension between the realities of oncology social work practice and practitioner expectations was cited as the most plausible explanation for this surprising finding. This study result echoes other systemic stressors aforementioned in this reviewed literature such as unsupportive and toxic work cultures (Sprang et al., 2007; Kapoulitsas & Corcoran, 2015). It suggests that more attention must be placed towards creating salutogenic environments for clinicians, of all levels of licensure, where they are supervised to have appropriate and balanced expectations of personal and systemic limitations. Radey and

Figley (2007) suggest that “compassion satisfaction is not an easily attainable goal; nonetheless, clinicians can take concrete steps to reach this satisfaction improving both personal well-being and service provision for clients” (p. 213).

Occupational Vulnerabilities for End of Life and Palliative Care Clinicians

As aforementioned in this literature review, being intimately involved with the suffering of others has a profound impact on helping professionals. End of life and palliative care (EOLPC) clinicians come into close contact with the physical, psychological, spiritual, and emotional suffering of their patients on a regular basis. Some EOLPC professional responsibilities include “providing intensive interventions aimed at promoting healing, improving quality of life, relieving symptoms, and supporting dignified care at the end of life” (Rushton, Kaszniak, & Halifax, 2013, p.1). Additionally, mental health clinicians in EOLPC settings such as medical social workers and psychologists are expected to provide psychosocial coping support for families and patients confronting life-threatening illness with love, empathy, and compassion (Harper, 2011). Regardless of their clinical scope of practice, all EOLPC clinicians are expected to be capable of routinely engaging in difficult conversations about medical treatment and end of life decisions.

Numerous studies have confirmed the presence of compassion fatigue and burnout symptoms amongst this population of clinicians (Chan, Fong, Wong, Tse, Lau, & Chan, 2016; Sansó et al., 2015, Quinn-Lee et al, 2014, Whitebird et al., 2013, Perez, Haime, Jackson, Chittenden, Mehta, & Park, 2015). The following section will focus on literature that addresses systemic stressors, patient stressors, personal challenges, and strategies for coping and resilience amongst EOLPC clinicians.

Systemic Stressors. End of life and palliative care is usually offered through an inpatient

hospital or in-home setting but may also be offered in community or freestanding hospices and assisted living facilities (Rokach, 2005). Most of these settings operate within a medical/healthcare model that expects clinicians to conduct best practices with their patients while still meeting daily patient quotas and maximizing the organization's profit. Perez et al (2015) outlined numerous systemic and environment related stressors in their qualitative study of 15 palliative care clinicians at a major teaching hospital. Their study results cited the following systemic stressors for EOLPC clinicians: unreasonable and competing time demands, unpredictable scheduling, conflicting expectations, and high volume caseloads (Perez et al., 2015, p.335). One study participant illustrated how these systemic stressors reflect the theme of "not-knowing" that is present in so many other aspects of EOLPC,

Sometimes I don't know at 5:59 whether I'm going to be out at 6:00 or 6:30. You don't know because you think [it'll be] a 15- minute patient...and you walk through the door and there's five family members there because they just happened to come from out of town and they have a million questions and before you know it your 15-minute...turns into an impromptu two-hour family meeting (Perez et al., 2015, p. 335).

This type of scheduling unpredictability and accepted boundary crossing could be particularly harmful for an EOLPC clinician managing symptoms of burnout or compassion fatigue.

With the exception of mental health clinicians and medical providers working in private practice, most EOLPC clinicians work as part of an interdisciplinary team (IDT). IDT teams are most frequently comprised of medical social workers, physicians, nurses, chaplains, personal care/nursing aides, volunteers, and occupational/speech/physical therapists (Rokach, 2005). In an ideal world, the IDT model is meant to provide a supportive and collaborative team environment for EOLPC clinicians. The reviewed literature has pointed out that skillful collaboration may not

always be possible in the face of limited resources, differences in education, training, self-awareness, empathy, extreme stress states, and CF.

Breen, O'Connor, Hewitt, and Lobb (2014) conducted a qualitative study with 38 professionals who provide grief support and counseling for cancer and palliative care patients. Their study's grounded theory methodology revealed numerous themes of challenges that are unique to EOLPC clinicians. One salient theme was the impact of emotional demands on professionals working in an IDT team. Participants in the study discussed how time spent interfacing with their colleagues could be a source of additional stress. The following quote from a study participant illustrates some of the challenges of working with other professionals,

To be quite frank, it's taxing for therapists...It's hard work, and unlike the medical profession, we're trained to be empathic and to build a connection so it's taxing for us. Whereas medically, they're trained to be more detached, and they have to be, but that's part of the problem too, because patients are aggrieved by that "matter-of-factness" (Breen et al., 2014, p. 64).

Looking through a CF theory lens, IDT teams may pose a risk of constant trauma re-exposure for clinicians. Clinicians who have CF may experience symptom exacerbation when their colleagues are casually discussing cases or "venting" as is common in IDT settings. Thus, the IDT team model is yet another complex web of support and challenge that EOLPC clinicians must learn to disentangle for themselves.

Patient-centered stressors. Results from the two aforementioned empirical studies both outlined stressors directly related to patient care. Perez et al. (2015) identified two main patient-centered stressors, the intensity of cases and managing patient and family expectations. Both studies spoke to the life threatening illness and death that clinicians are exposed to with

frequency and intensity (Perez et al., 2015; Breen et al., 2014). Unlike other mental health clinicians, EOLPC clinicians may not have the choice to diversify their caseload to minimize trauma exposure.

An important part of EOLPC work is supporting an entire family system, which often includes members that have conflicting views about their loved one's care and needs (Breen et al., 2014). Clinicians are often placed in a role of moderator during family conflicts that arise at the end of life or during a health crisis. Families are often not in agreement with the patient's wishes or clinician's recommendations. Thus, EOLPC clinicians must cope with the challenges of receiving frustration, disappointment, and rage from their patients and/or their loved ones on a regular basis. This unique stressor may contribute to the development of CF symptomatology and burnout because of the way that receiving intense and potentially traumatizing affect from others may contribute to feelings of professional and personal inadequacy.

Personal Challenges: Grief and Death Anxiety. Numerous sources in the literature on EOLPC professionals have named personal history of illness and loss as one of main motivating factors for entering the field (Simon et al, 2006; Supple-Diaz & Mattinson, 1992; Quinn-Lee et al., 2014). The fact that many EOLPC clinicians may be “wounded healers,” individuals called to their work to heal from direct experiences of their own suffering, may add another level of stress and complexity to the work (Renzenbrink, 2004, p. 859). All of the respondents in the study by Perez et al. (2015) reported difficulties setting and maintaining their boundaries with patients. This finding is particularly relevant for mental health clinicians who usually spend more time in session with patients and families discussing difficult affective content than their IDT colleagues in medical settings. A clinician's inability to have healthy differentiation with their patient's suffering and maintain ethical boundaries, could be a liability for their own self-care and

wellbeing.

The literature has also cited death anxiety and personal grief as additional sources of personal stress for EOLPC clinicians (Quinn-Lee et al., 2015, Simon et al., 2006). Mallett, Price, Jurs, and Slenker (1991) discussed how death anxiety is, “multifaceted and encompasses concerns related to the denial of death, the fear of death for oneself and for others, avoidance of death, and the reluctance to interact with persons who are dying” (as cited in Quinn-Lee et al., 2014, p. 222). Gawande (2014) argues that death anxiety in the United States is embedded in the culture and healthcare systems. In many ways, EOLPC clinicians are in a field that is subverting the cultural and systemic norms. The literature has shown that this challenging facet of the work can also lead to social isolation (Rokach, 2006). EOLPC clinicians are invited on a daily basis to engage with work that one EOLPC chaplain described as “a profound contemplation of our own mortality” (Deleo, 2012, p. 251). This “contemplation of mortality” may lead clinicians, particularly novice ones, to experience high levels of death anxiety. This anxiety may increase exponentially if the clinician is treating someone who is their age or if they are concurrently caring for a family member at the end of their life.

Quinn-Lee et al. (2014) conducted a mixed method study with 290 hospice social workers to examine death anxiety and burnout. The study revealed “nearly three-quarters of the respondents reported a perceived overall decrease in their personal level of death anxiety as they spent more time working as hospice social workers” (Quinn-Lee et al, 2014, p. 230). These study results suggest that novice hospice social workers need mentorship and unique training to navigate the initial stages of adjustment to facing their own death anxiety in their work with dying patients. Additionally, Breen et al. (2014) pointed out that most graduate level educational programs do not train clinicians to provide grief and loss support. This finding confirms that

many EOLPC clinicians may not have been trained or supervised in some of the skills needed to bear witness to suffering/death, surrender to not knowing, and accept ambiguity.

Strategies for Coping and Resilience. The reviewed literature has highlighted that EOLPC clinicians have a unique and powerful role in the caring process for the people they serve (Sánsó et al, 2015). This role requires that clinicians have professional and personal structures of support to sustain them in the work of facing illness and death on a daily basis. Work environments that support EOLPC clinicians to maintain appropriate work boundaries, set limits for caseloads, and address their professional grief have been cited as a main determinant of resilience in the face of burnout, vicarious traumatization, and compassion fatigue (Clark, 2011). Self-care strategies cited in the literature such as establishing rituals and effective grieving practices suggest that creating space for professional grief and countertransference is one of the cornerstones of coping and resilience for EOLPC clinicians (Renzenbrink, 2004).

A 2007 quantitative study conducted with 215 hospice IDT members used the Jarel Spiritual Well-Being, Chamiec-Case Spirituality Integration, and Job Satisfaction scales to assess if job satisfaction and spirituality were correlated (Clark, Leedy, McDonald, Muller, Lamb, Mendez, Kim, & Schonwetter, 2007). The study found that "98% of respondents viewed themselves as having spiritual well-being"(Clark et al., 2007, p. 1321). Most of these respondents also reported high job satisfaction. Findings from this study suggest that spirituality may be related to higher job satisfaction for clinicians working intimately with dying patients. Further research on the prevalence of spirituality amongst IDT hospice and palliative care team members is needed to discern if spirituality is in fact a source of resilience and support beyond job satisfaction. The following section of this literature review explores the connections between spiritual practices and self-care in relation to compassion fatigue, compassion satisfaction,

burnout, and EOLPC work.

Spiritual Practice as a Protective Factor

Spirituality has been researched extensively over the past few decades in an attempt to understand how individuals make meaning, navigate life's most existential issues, and connect with the world around them. The literature on spirituality in the fields of social work and psychology has focused mostly on examining how spiritual and religious coping skills may protect an individual's cognitive schemas in the face of trauma (Cunningham, 2014). Jacobs (2015) provided a framework for understanding the connection between spiritual perspective taking and thriving in the field of social work: "our spiritual perspectives are related inextricably to our understanding of suffering and hope, as well as to our capacity to accomplish personal and collective goals" (p. 152).

Empirical studies have also illustrated that certain aspects of spirituality, such as meaning/purpose and interconnectedness can serve as predictors of empathy (Giordano, Prosek, & Lankford, 2014). Almost all of the literature reviewed in this chapter has cited spirituality as a form of self-care (Gregory, 2015; Cunningham, 2004; Decker et al., Harrison & Westwood, 2009; McGarrigle & Walsh, 2011). As aforementioned, self-care is one of the main themes in balancing compassion fatigue and compassion satisfaction (Radey & Figley, 2007). With that said, there has been a lack of empirical research conducted to measure the impact of engagement in regular spiritual practice on EOLPC clinicians.

Spiritual/Contemplative Practices. Social work theorists have discussed the importance of contemplative practices and spirituality for creating "a transitional and therapeutic space" (Jacobs, 2015, p. 150). For the sake of this study, the labels spiritual and contemplative will be used interchangeably to discuss practices that facilitate an individual's connection to "meaning,

purpose, and an experience of their connectedness to the moment, self, others, nature, the significant, or sacred” (Puchalski, Ferrell, Virani, Otis-Green, Baird, Bull, & Sulmasy, 2009, p 887).

Jacobs (2014) framed contemplative practices as intimate ways of experiencing and knowing the inner and outer landscapes of our being. Rushton, Sellers, Heller, Spring, Dossey, and Halifax (2009) provided the following definitions for contemplative practices that are featured in the reviewed literature:

Mindfulness: A practice that brings together concentration and insight by training the mind to bring attention to 1) the present moment, 2) responses to phenomena, (3) awareness of mental states, 4) experience objects of the mind.

Yoga: Yoga focuses on harmony between mind and body using movement, breath, posture, relaxation, and meditation in order to establish a healthy, lively, and balanced approach to living

Meditation: a General term that is used to describe a practice or set of practices to engender mindfulness (as cited in Rushton et al., 2009, p. 406).

Duerr (2011) asserted that contemplative practices have the potential to enhance self-awareness, foster compassion, and deepen feelings of interdependence with all things (as cited in Jacobs, 2014, p. 152). Characteristics developed from contemplative practices such as self-awareness, relaxation, harmony, and reflection are related to the characteristics found in the protective practices outlined in the CF and VT literature (eg. supervision, self-care, and appropriate boundary setting). Similarly, research from CS studies suggested that feelings of deep connection to oneself and the world outside of their work could encourage a balanced and fulfilling professional life (Perez et al., 2015).

A quantitative study conducted by Sansó et al. (2015) focused on the relationship between compassion, self-care, and awareness amongst 387 Spanish speaking palliative care professionals. Sansó et al. (2015) found that participants with higher levels of reported self-awareness (measured using the Mindful Attention Awareness Scale) also scored higher in death coping competence measures on the Coping with Death Scale. The study sample's results from the Professional Quality of Life Scale (ProQOL), which measures for CF/CS/BO, indicated that professionals with higher levels of reported awareness had lower levels of CF and BO, and higher levels of CS respectively. When combined, these results suggested that activities, such as particular contemplative practices, that help clinicians develop and increase their self-awareness might also improve death competency and assuage death anxiety.

Results from Contemplative Training Programs. New breakthroughs in neuroscience over the past decade have sought to validate the benefits of particular contemplative practices like yoga and mindfulness meditation into the scientific body of research. Three recent empirical studies have focused on training programs intended to increase self-care and wellness amongst populations of professional helpers who are at high risk for CF. The first study, conducted by McGarrigle and Walsh (2011), used a mixed methods design to assess how an 8-week meditative group session impacted wellbeing in a group of twelve social workers. Study participants practiced numerous contemplative exercises such as yoga, mindfulness, relaxation, mindful walking, and listening exercises in addition to journal reflection and group discussions. Quantitative data in the study was collected using the Perceived Stress Scale and the Mindfulness Attention and Awareness Scale. Researchers collected qualitative data through written journal entries from participants.

McGarrigle and Walsh (2011) found that their training program led to a “significant

increase in mindfulness and significant decrease in stress pre to post training” (p. 220). The researchers postulated that increased mindfulness assisted social workers to become aware of their stress and effectively manage it. Stress management, achieved through contemplative exercises, was associated with increased feelings of wellbeing. The study’s qualitative results revealed three main themes: accountability, mindfulness, and workplace context (McGarrigle & Walsh, 2011, p. 220). Study participants suggested that their work environment, along with leadership and staff members, is responsible for training social workers in strategies to support self-care and overall wellbeing (McGarrigle & Walsh, 2001, p. 227). The study results confirmed that there is an overarching need for workplace cultures to create space that would allow clinicians to practice contemplative practices.

Gregory’s (2015) study used the ProQOL V to measure CF and CS alongside of a mindfulness and yoga-training program. The study employed a quasi-experimental method to collect quantitative data, with a pre test and post test design. A small sample of 6 social workers participated in a three-week mindfulness and yoga-training program, while the control group did not receive any contemplative training. The study’s post test results for compassion satisfaction showed a difference in CS between the control group and experimental group (Gregory, 2015, p. 382). Qualitative data was collected through questionnaires at post-test and pre-test for both groups. The most salient qualitative results from the study were related to how social work participants experienced working with particularly challenging clients. All of the study participants in the experimental group reported a change in their work to a client they had difficulties with at the pre-test screening. The results of this study confirmed the efficacy of yoga and mindfulness in increasing compassion satisfaction. Additionally, the study illustrated that certain contemplative practices could also support clinicians develop equanimity in the face of

working with difficult clients.

Rushton et al. (2009) conducted a mixed methods study with 134 total participants from Being With Dying: Professional Training Program in Contemplative End of Life Care (BWD). This program was created to address the unique needs of EOLPC clinicians. BWD uses contemplative practices, such as yoga and mindfulness meditation, in addition to didactic teaching, creative processes, and self-directed learning (Rushton et al., 2009, p. 406). The qualitative data led to four salient themes: the power of presence, cultivating balanced compassion, recognizing grief, and the importance of self-care. These themes are consistent with themes cited in aforementioned studies on CF and EOLPC.

Quantitative survey results from Rushton et al. (2009) spoke to the efficacy of the BWD program. Respondents reported on increases in their own qualities of presence, skillful listening (76%), ability to stay centered (77%), and achieving balance in the face of change (65%) (Rushton et al., 2009, p. 408). Additionally, survey data revealed that the program led participants to develop greater compassion towards themselves (83%) and others (81%). An overwhelming majority of respondents (80%) claimed to have more balance in the face of navigating the suffering and pain of their patients (Rushton et al., 2009, 408). The program was also effective in supporting clinicians to become more aware of their grief reactions (79%) (Rushton et al., 2009, 408). Lastly, the program led to an increase in survey respondents' commitment and participation to self-care (87%) (Rushton et al., 2009, 408).

The three reviewed studies on contemplative practice trainings indicated that there is both a need and demand amongst social workers and EOLPC clinicians for education and support in mitigating the negative impacts of their work. Furthermore, the studies have shown that particular practices and training can enhance clinicians' feelings of wellbeing, fulfillment, and

presence in their work with individuals who are suffering. More research is needed to understand how the aforementioned spiritual practices are connected to development of empathy, the main CF predictor as cited in the reviewed CF literature.

Biases and Limitations in the Previous Literature

Unfortunately, the literature thus far has not looked at the whole picture of how spiritual practice relates to CF and CS within a population of mental health clinicians in EOLPC settings. There are some assumptions in the literature reviewed and in this study that spirituality, as a self-care method, will positively impact EOLPC clinicians who are faced with unique existential challenges in their work. This hypothesis must be further tested in a reliable and reproducible way, specifically with EOLPC clinicians who are exposed to high levels of stress and naturally occurring traumatic events. This literature review included mostly quantitative and mixed methods studies, although a few employed a strictly qualitative design.

Studies on spiritual practices have only focused on a few types of mainstream practices like yoga and mindfulness meditation. In the United States these practices have been mostly accessed and embraced by members of predominantly White communities where traditional religious practices like prayer or devotional acts may not be as widely practiced or accepted. The lack of empirical data on other spiritual practices such as prayer, chanting, nature walking, art making, and reflective writing, prevents the field from being able to understand all the unique aspects of spirituality that may be adaptive and supportive for EOLPC clinicians. Additionally, the lack of research on spiritual practices that are more closely related to religious activities limits our understanding of how religious belief systems interface with CF and CS.

Overall, the literature available for review has privileged the perspectives of White middle-aged clinicians and professionals. This reality prevented gathering a deeper

understanding of how racial identity, age, culture, socioeconomic status, and sexual identity factor into experiences of CF, CS, and understandings of self-care and spiritual practice. Additionally, most of the studies named a mostly female identified group of participants as a limitation. There was only one study conducted by Sansó et al (2015) that included non-English speaking palliative care professionals from across the world. The rest of the studies that examined spiritual practices, CS, CF, BO, and VT, had negligible numbers of participants of color or participants that were male identified. Racial and sexual identities of participants were not discussed in any of the studies found. This suggests that researchers are not taking issues of oppression into account when examining professionals' experiences of compassion fatigue, burnout, or compassion satisfaction.

Summary

Compassion fatigue has been documented with EOLPC clinicians as well as clinicians who treat traumatized individuals. Engaging with life threatening illness and death on a regular basis poses some unique challenges that require additional professional, educational, and personal support. Spiritual practices have been found to enhance wellbeing, levels of compassion satisfaction, and increase self-awareness. Self-awareness has been cited throughout the literature as an important factor in maintaining appropriate work/personal boundaries, asking for support, and identifying symptoms of compassion fatigue. Awareness appears to be a key ingredient for EOLPC mental health clinicians that are facing death anxiety. There has been insufficient literature to identify if and how spiritual practices support EOLPC clinicians in mitigating compassion fatigue symptoms and increasing compassion satisfaction. Exploring the prevalence of CS, CF, and participation in spiritual practice is necessary to create a framework that supports

clinicians. Additionally, research must be conducted in this area of interest to assess the need for including spiritual practice as a self-care strategy in educational programs.

CHAPTER III

Methodology

The following chapter describes the methods used to conduct this research study. To date there have not been sufficient quantitative studies that consider how participation in spiritual practice relates to the professional and personal experiences of end of life and palliative care mental health clinicians. The purpose of this study was to explore the following research question: how is participation in spiritual practice related to self-reported levels of compassion fatigue and compassion satisfaction among mental health clinicians working with clients receiving end of life and/or palliative care (EOLPC)? Based on the literature reviewed, I hypothesized the following: 1) Participation in spiritual practice would be negatively correlated with self-reported levels of compassion fatigue. 2) Participation in spiritual practice would be positively correlated with self-reported levels of compassion satisfaction. 3) Participation in spiritual practice acts as a protective factor against compassion fatigue and burnout for spiritual practitioners.

Research Method and Design

This exploratory study utilized a quantitative design to gather data in an online questionnaire. The online questionnaire (Appendix F) utilized three item formats to gather information: closed multiple-choice questions, open-ended questions, and Likert-scale type statements. Open-ended questions were included to offer participants an opportunity to add personalized and narrative elements about their experience with spiritual practice and

professional work to the data set. A deeper analysis of major themes found in these open-ended questions is featured in the discussion section of this thesis.

The Human Subjects Review Board at Smith College School for Social Work approved the study's methodology (Appendices A and B) before I began recruitment. Snowball and purposive sampling was used to recruit study participants. Participants were recruited using two main methods, e-mail and the social networking tool Facebook. I e-mailed a recruitment letter (Appendix D) and a link to the online questionnaire to colleagues and professional contacts at hospitals and cancer centers in Massachusetts, New York, and California. An e-mail recruitment letter was also sent to the following organizations: Social Work Hospice and Palliative Care Network, Association of Oncology Social Workers, National Association of Black Social workers, Latino Social Workers Organization, Upaya Zen Center (Being with Dying Program), New York Zen Center for Contemplative Care, Living/Dying Project, and the Conscious Dying Network. Recruitment with these organizations was intended to create a large and diverse sample. A recruitment advertisement (Appendix E) was also posted and shared on my personal Facebook page. Lastly, this ad was posted and shared on some of the aforementioned organizations' Facebook pages.

This study's recruitment strategy and design had some clear limitations. The snowball sampling method increased the likelihood that participants shared similar characteristics such as professional field, gender identity, and participation in spiritual practice. Purposive sampling was intended to balance out this limitation by intentionally recruiting clinicians of color and members of professional organizations that were not spiritually or religiously affiliated. The study's design made it user-friendly to clinicians that had access to a computer and were regularly connected to the Internet. A limitation of an online data collection method was that clinicians who were not

connected to the virtual spaces where I posted recruitment letters and advertisements did not have access to participate in the study. With that said, the study design and recruitment strategy made the study more feasible to conduct in a limited time frame and budget.

Sample

Eligible participants in this study sample were required to fulfill the following eligibility criteria a) over 25 years of age; b) literate in English; c) had a graduate degree from a master's level program in the following fields: clinical social work, clinical psychology, marriage and family therapy, mental health counseling psychology; d) had worked with patients receiving palliative care or hospice services for at least two years. I chose to only survey clinicians over the age of 25 in an effort to recruit practitioners that had some experience working in the field since graduating from their graduate programs. The inclusion criteria of two years in the EOLPC field was intended to increase the likelihood that clinicians had experienced some of the symptoms of compassion fatigue and compassion satisfaction.

Eligible participants were not required to identify as spiritual practitioners to complete the survey. This criterion was intended to help recruit a diverse sample of data that could elucidate if participation in spiritual practice was related to compassion fatigue and satisfaction reporting. The online survey had a preliminary screening mechanism to ensure that participants met the aforementioned inclusion criteria before taking the survey.

This study's inclusion criterion was narrow and excluded professionals from other disciplines such as medicine and chaplaincy from the EOLPC field. These professionals were intentionally excluded from the sample in an effort to contribute to a new body of research with clinicians who embody unique psychosocial supportive roles in EOLPC work. Non-English speaking clinicians were also excluded from this study because the timing of this research did

not allow for devising additional versions of the online questionnaire. I recognized that the nature of this study's design privileged the narratives and experiences of White and English speaking clinicians. The discussion section of this thesis addresses the potential impacts and consequences of conducting a study whose design inherently privileges a sample from a majority group.

This study's final sample consisted of 55 eligible participants. The method and time frame for collecting data significantly limited the number and diversity of eligible participants. This study's statistical consultant removed 22 cases whose participants either did not meet eligibility criteria or did not say "yes" to informed consent.

Ethics and Safeguards

The study's online questionnaire was administered through Qualtrics, a software that did not collect any names, e-mail addresses or IP addresses. In this way anonymity was guaranteed to participants. Participants were advised in the electronic informed consent form to refrain from disclosing any identifying information in open-ended questions. Qualtrics designated a code number automatically to all participants' responses. I reviewed all responses to open-ended questions to ensure that identifiable information was removed before sharing data with research advisor and statistician.

Study participants had the choice to leave the questionnaire at anytime. Although incomplete data was saved through the survey software, I did not use partial survey responses (less than 50% completed) in findings. My research advisor and the statistical consultant had access to the data after Qualtrics completed coding and I removed all identifying information. All data collected was secured electronically and protected by password and encryption. All participants received the same treatment and were given the same online questionnaire. I did not

have contact with participants with the exception of participants that contacted me via email with questions.

This proposed study had minimal risks of participation beyond that it could potentially cause distress for some participants. Participants were not asked to discuss specifics of their trauma work with clients or any aspects of trauma in their own history. Additionally, the questions were meant to encourage participants to examine experiences of satisfaction and resiliency associated with working with individuals in an end of life/palliative care setting. Testing for both compassion satisfaction and compassion fatigue was intended to provide participants with an opportunity to examine their own professional joys and challenges.

All participants received a referral list with the informed consent form (Appendix C). Before agreeing to the informed consent each participant was asked to print a copy of the informed consent and referral list to keep for their records. Informed consent was built into the online questionnaire as a forced response page to ensure consent before participation. The referral list consisted of three national resources that the participant could contact if they felt the need to talk to someone at any point while taking the survey, after taking the survey, or if they chose not to take it.

Instrumentation

This study's quantitative survey consisted of three major sections. Participants began the survey with an eligibility screening. They were directed to the electronic informed consent page (Appendix C) if they screened positively for all eligibility criteria. If they did not screen positively, they were directed to a disqualification page. Eligible participants continued onto the first section of the survey, "demographic information." This section asked participants to answer multiple-choice questions about their ethnic/racial identity, gender identity, professional

discipline, and practice setting. Participants had the option to write in their own answers to the demographic questions about racial/ethnic identity, gender identity, and practice setting if they did not identify with one of the choices offered. Additionally, participants were given the option to abstain from answering questions about racial/ethnic and gender identity. Demographic categories were included in the survey instrument to assess if there were any additional relationships between demographic identifying information and levels of self-reported compassion fatigue/satisfaction.

The second section of the survey utilized the Professional Quality of Life Scale Version 5 (ProQOL V) (Stamm, 2010) to measure levels of compassion satisfaction, burnout, and compassion fatigue. This scale recognized secondary traumatic stress and burnout as elements of compassion fatigue (Stamm, 2010). The terms compassion fatigue and compassion satisfaction were briefly defined for participants in the informed consent form. The ProQOL V was free to use for research purposes as long as the author was credited and wording remained the same within particular parameters. I followed these guidelines and changed words like “helper” and “help” to “clinician” and “work” to fit the study sample. Examples of statements from my adapted version of the ProQOL V were:

I feel connected to others.

I jump or am startled by unexpected sounds.

I feel invigorated after working with those I help.

I find it difficult to separate my personal life from my life as a clinician.

I am not as productive at work because I am losing sleep over traumatic experiences of a person I work with.

The ProQOL V measured secondary traumatic stress, compassion satisfaction, and burnout using a construct specific ten-question subscale. The scale used an ordinal level of

measurement (Likert scale) to measure variables (1- Never 2- Rarely 3-Sometimes 4- Often 5- Very Often). I chose the ProQOL because of its reliability and validity. At least 50 of the published papers on compassion fatigue, secondary traumatic stress, and vicarious traumatization have used the ProQOL V or one of its earlier versions (Stamm, 2010).

The survey concluded with questions intended to measure participation in spiritual practice. This section's first question was a preliminary screening to assess if the respondent participated in spiritual practice. Spiritual practice was defined as "a recurrent activity that you engage in to experience meaning, purpose, and your connectedness to the moment, self, others, nature, the significant, and/or sacred." This definition was inspired by definitions of spiritual and contemplative practices found in the reviewed literature (Puchalski et al., 2009, Cunningham, 2004; Hollingsworth, 2008; Jacobs, 2014; and Rushton et al., 2009). I felt that this definition created space for participants to include and express a variety of different understandings of spiritual practice. This definition was also intended to include participants in the study whose spiritual practices in other contexts may have been minimized because of dominant christonormative cultural values (Ferber, 2012).

Participants who answered "yes" to participating in a spiritual practice were directed to three additional questions about their spiritual practice. Respondents that answered "no" to participating in a spiritual practice were directed to the end of the survey. A multiple-choice question with an optional fill in design was used to assess for frequency of participation in spiritual practice. This question was included to assess if frequency of practice was related to self-reported levels of compassion fatigue and compassion satisfaction. Lastly, two open-ended questions were included to allow for participants to describe their spiritual practice in detail and discuss if and how they felt that it supported their work. The decision to use a combination of

Likert-scale, multiple choice, and open-ended questions was intended to safeguard against overlooking important themes that the ProQOL V did not address. Even though this exploratory study attempted to look at a narrow topic, I hoped that the variance in question design would lead to a deeper analysis and discussion.

Data Analysis

All data analysis was processed with the assistance of Marjorie Postal, the statistical consultant from the Smith College School for Social Work. Data from 55 cases was organized and assessed using Excel. Validity of the ProQOL V was measured using Cronbach's alpha, a test of internal reliability to see how well the three subscales fit together. Specific data collected using the ProQOL scale was analyzed using the ProQOL V manual and scoring guide.

Hypotheses of association were tested using inferential statistics. Spearman's rho, a non-parametric correlation test of association, was used to test whether there was a relationship between participation in spiritual practice and self-reported levels of compassion fatigue, compassion satisfaction, and burnout obtained from the ProQOL V. A oneway analysis of variance, ANOVA, was used to determine if there were any differences between the mean ProQOL CS, BO, and CF scores according to demographic groups. Additionally, t-tests were run to determine if there were differences in the ProQOL V scores from each subscale (compassion satisfaction, secondary traumatic stress, or burnout) by answers "yes/no" to the question about participation in spiritual practice. Lastly, qualitative responses were coded using thematic analysis.

Discussion

There were some limitations to this study design. The main limitation was that the survey instrument did not address additional variables that could be related to self-reported levels of

compassion fatigue and compassion satisfaction. Thus, it was difficult to assess what other factors may have contributed to the results from the ProQOL V. As aforementioned, the study design was also unable to ensure that all racial identities were represented because the professional disciplines included in the eligibility criteria were all disproportionately White. Additionally, this study excluded non-English speaking clinicians, clinicians that might not be computer literate, and clinicians that did not have access to the Internet. The design of the survey instrument's section on spiritual practice may have also inadvertently privileged particular secular expressions of spiritual practice.

As aforementioned, this study was intended to explore the phenomena of compassion fatigue/compassion satisfaction and determine if participation in spiritual practice was related to self-reported levels of CS and CF. Although I worked diligently to create a study that would minimize methodological bias, some was unavoidable. My identity as a practitioner of Zen Buddhism, yoga, and shamanic practices certainly impacted how I developed the survey instrument. The mention of the term "spiritual practice" in the recruitment letter may have also made the study more appealing to clinicians who already believe their participation in spiritual practice supports their work. Consequently, the mention of "spiritual practice" may have made the study less appealing to clinicians who do not have a spiritual practice or believe in spiritual practice as a protective factor.

Additionally, my professional role as a medical social work intern in the EOLPC field may have also contributed to bias in data analysis. With that said, I was precisely interested in and committed to this research because I wanted to find data that would reveal the ways that clinicians might be able to more effectively navigate the psychological and emotional risks of this work. I chose quantitative research methods and the ProQOL V as an instrument to increase

the validity of this study and minimize misinterpretation of the data due to my own personal bias and experiences.

CHAPTER IV

Findings

This study sought to answer the following research question: how is participation in spiritual practice related to self-reported levels of compassion fatigue and compassion satisfaction among mental health clinicians working with clients receiving end of life and/or palliative care (EOLPC)? The online survey was designed to gather information about the prevalence of compassion fatigue and compassion satisfaction within the sample (N=55). Additionally, the survey assessed for levels of participation in spiritual practice, types of spiritual practices represented, and the supportive impact of spiritual practice on clinical work. Data was collected to test the following hypotheses: 1) Participation in spiritual practice would be negatively correlated with self-reported levels of compassion fatigue. 2) Participation in spiritual practice would be positively correlated with self-reported levels of compassion satisfaction. 3) Participation in spiritual practice acts as a protective factor against compassion fatigue and burnout for spiritual practitioners.

Study findings are organized into three sections. The first section presents participant demographics, including professional discipline, racial/ethnic identity, gender identity, and practice setting. Survey results from the Professional Quality of Life Scale (ProQOL V) are presented in the second section. Quantitative findings about participation in spiritual practice are presented in the third section. This chapter concludes with qualitative findings from open-ended questions pertaining to participation in spiritual practice.

Participant Demographics

Table 1

Participant Demographic Characteristics (N=55)

Variable		Valid %(n)
Professional discipline	Clinical social work	96.3% (52)
	Clinical psychology	1.9% (1)
	Mental health counseling	1.9% (1)
Practice setting	Inpatient hospital unit	25.6% (14)
	Outpatient medical clinic	35.2% (19)
	Community mental health center/agency	9.3% (5)
	Client homes/homecare agency	13% (7)
	Personal office space	3.7% (2)
	Other	13% (7)
Race/ethnicity	Hispanic/Latino/Spanish origin	1.9% (1)
	White	90.7% (49)
	Middle Eastern	1.9% (1)
	Native American	1.9% (1)
	Other	1.9% (1)
Gender/gender identity	Female	94.4% (51)
	Male	5.6% (3)

The demographic findings presented in Table 1 were taken from responses provided by 55 eligible study participants. A total of 77 individuals clicked on the online survey link but either did not meet eligibility criteria or complete the survey in its entirety. The majority of the sample (96.3%) was comprised of individuals who identify with the professional discipline of clinical social work. The professional disciplines of clinical psychology and mental health counseling were also represented in the sample. The first largest group of participants in the sample (35.2%) reported practicing most often in outpatient medical clinic settings. The second largest group of participants (25.6%) reported practicing most often in inpatient hospital units. Remaining participants identified with practicing in client homes (13%) and in “other” settings

that were not offered as options (13%). The online survey offered participants an opportunity to describe their practice setting if it was not listed as an option. Participants that selected the option “other” named the following additional settings where they practice EOLPC work: comprehensive cancer center, combined office/in home private practice, inpatient hospice, cancer support center, combined inpatient/outpatient setting, in home hospital pediatric palliative care team, and in home hospital bereavement program.

The survey offered ten possible ethnic/racial categories of identification: Black or African American, Hispanic/Latino/or Spanish origin, Asian, White, Middle Eastern, Native American, Alaskan Native, Pacific Islander, Mixed race or Biracial, and other. The majority (90.7%) of participants identified racially/ethnically as White. Remaining participants from the sample identified with the following racial/ethnic categories: Native American, Middle Eastern, and Hispanic/Latino/Spanish Origin. One participant who selected “other” identified as “Semitic.” Only one participant did not disclose their racial/ethnic identity. The survey offered five possible choices for gender identity: male, female, transgender, genderqueer, and other. Of the 55 participants, 94.4% identified as “female.” The remaining participants (5.6%) in the sample identified as “male.” One participant did not disclose their gender identity. This sample’s homogeneity, although representative of the demographics of the field of clinical social work, limited statistical analysis.

Findings on Compassion Fatigue, Compassion Satisfaction, and Burnout

As aforementioned, this study utilized the ProQOL V to assess the prevalence of compassion fatigue (CF), burnout (BO), and compassion satisfaction (CS) within the sample. The ProQOL V utilizes individual ten item subscales to measure each construct. Compassion fatigue is measured by combining the burnout (BO) and secondary traumatic stress (STS) cut

scores. Internal reliability of BO, STS, and CS subscales was tested using Cronbach's alpha. Alpha scores ranged from .78 (BO) to .79 (CF) to .91 (CS) and indicated that all three subscales in the ProQOL V had strong internal reliability. The average (50th percentile) ProQOL score for each of the subscale constructs (BO, CF, STS) is 50 (Stamm, 2010).

Table 2

Professional Quality of Life Scale Results

ProQOL Subscale	Lowest Score	Mean Score (m)	Highest Score	Mean ProQOL score (M)
Compassion Satisfaction	31	43.21	50	50
Burnout	10	19.01	27	50
Secondary Traumatic Stress	10	18.03	29	50

Table 2 outlines scores from participants' responses to the ProQOL V measure. The above results indicate some variance from the average CS, BO, and STS scores (mean=50) outlined in the ProQOL scale data (Stamm, 2010). This study's sample of participants had a slightly lower score in compassion satisfaction (m=43.21) than the average taken from studies in the ProQOL database (M=50). The sample's mean CS score falls within the range of the ProQOL bottom quartile score of 44. This data indicates that participants in the sample were within the 25th percentile of scores from the ProQOL database. Mean burnout (19.01) and secondary traumatic stress (18.03) scores in the sample fell far below the average score in the ProQOL guide. The sample's BO and STS scores are significantly below the 25th percentile of scores from the ProQOL database (M=43 and 42 respectively) (Stamm, 2010).

When grouped together, the sample's ProQOL scores featured in Table 2 suggest an overall trend of moderate to average compassion satisfaction and very low burnout and secondary traumatic stress. This grouping suggests that participants in the sample derive some

pleasure and fulfillment from their work and struggle less with the symptoms of compassion fatigue than the average helping professional who has taken the ProQOL V.

A oneway analysis of variance, ANOVA, was used to determine if there were any differences between the mean ProQOL CS, BO, and CF scores according to practice environment for the largest represented groups (inpatient hospital unit, outpatient medical clinic, client homes). No significant statistical difference was found. This study sample's lack of diversity (gender, race/ethnicity, and professional discipline) prevented further statistical analysis of ProQOL scores between demographic groups.

Quantitative Findings on Participation in Spiritual Practice

Table 3

Participation and Frequency of Spiritual Practice N=55

Question	Response	Valid % (n)	Missing % (n)
Do you participate in a spiritual practice?			7.3% (4)
	Yes	84.3% (43)	
	No	15.7% (8)	
How often do you participate in your spiritual practice?			21.8% (12)
	More than once a day	20.9% (9)	
	Daily	46.5% (20)	
	Weekly	20.9% (9)	
	Monthly	4.7% (2)	
	Other	7% (3)	
		7% (3)	

Table 3 presents quantitative data about participation in spiritual practice and frequency of participation in spiritual practice. Of the 55 survey participants, 43 (84.3%) answered “yes” to participating in a spiritual practice defined as a “recurrent activity that you engage in to experience meaning, purpose, and your connectedness to the moment, self, others, nature, the significant, and/or sacred” (Puchalski, et al., 2009). In comparison, 8 participants (15.7%)

answered “no” to participating in a spiritual practice. Participants who answered “no” to participating in a spiritual practice were directed to the end of the survey. Four participants (7.3%) did not answer the initial question about participation in spiritual practice.

Independent sample t-tests were used to determine differences between levels of STS, CS, and BO amongst participants who answered “yes” and “no” to engaging in a spiritual practice. No significant statistical differences were found. However, participants who answered “yes” to participating in a spiritual practice had a lower mean burnout score ($m = 18.49$) than those who answered “no” to participating in a spiritual practice ($m = 21.88$) $t(49) = 1.955$, two-tailed $p = .056$). Although not statistically significant, these results suggest that study participants who engage in a spiritual practice may experience differences in burnout symptomatology than participants who do not engage in a spiritual practice. The clinical significance of this finding will be further addressed in the discussion chapter of this study.

The quantitative and qualitative data that follows was taken from responses provided by the subsample of participants that either answered “yes” to participating in a spiritual practice or did not answer the question. From this subsample of participants, 20.9% participate in a spiritual practice more than once a day, 46.5% participate in a spiritual practice daily, 20.9% participate in a spiritual practice weekly, and 4.7% participate in a spiritual practice monthly. A few additional participants answered “other” to the question about frequency of participation in spiritual practice.

Spearman’s rho, a test of association, was used to assess whether there was a correlation between frequency of spiritual practice and secondary traumatic stress, burnout, and compassion satisfaction scores taken from ProQOL V responses. No significant statistical correlation was

found between levels of self-reported compassion fatigue, burnout, or compassion satisfaction and participation in spiritual practice.

Table 4

Perceived Support of Spiritual Practice in Clinical Work N=55

Question	Answer	Valid % (n)	Missing % (n)
Do you feel that participation in your spiritual practice supports your clinical work with clients receiving palliative and/or end of life care?	Yes	100% (42)	23.6% (13)
	No	0% (0)	

Table 4 illustrates that the majority of participants in the sample felt that their participation spiritual practice supported their clinical work in the end of life and palliative care field. The last section of this findings chapter presents data taken from participant responses to two open ended questions. These questions were intended to give participants the opportunity to reflect and report on the particularities of their participation spiritual practice and the relationship between their practice and clinical work in the end of life/palliative care field.

Qualitative Findings

The qualitative data presented below was coded and analyzed thematically. Themes outlined in Table 5 and 6 as well as relevant direct responses will be more thoroughly discussed and compared in the discussion chapter. The data was taken from responses to the survey question that asked participants to describe their spiritual practice. Table 5 (below) shows that prayer (15), attending religious services (13), and unspecified meditation practice (12) were the spiritual practices most frequently cited in qualitative responses. Engagement in spiritual community (10) and Yoga (9) were the themes that had the second most responses followed by being in nature (8), and reading spiritual literature (6). Overall, the sample was diverse in relation

to the types of spiritual practices that were represented. Additionally, there was a relatively equal representation of practices that fit into the following categories: secular, Eastern spiritual traditions, and Western religious traditions. The variety of responses suggested that participants appropriately interpreted the definition of spiritual practice offered. As aforementioned, this definition was intended to gather a variety of responses and create room for participants to express their own unique understandings of spiritual practice. Table 6 presents data from the last survey question that sought to gather themes related to the ways that spiritual practice supports participants' clinical work in the end of life/palliative care field.

Table 5

Types of Spiritual Practice

Themes from Qualitative Responses (responses can include more than one of the themes below)	n
Attending religious services	13
Prayer	15
Yoga	9
Meditation (practice type unspecified)	12
Mindfulness practice	1
Being in nature	8
Engagement in spiritual community	10
Listening to music	1
Reading spiritual literature	6
Religious study	4
Ethical Inquiry	2
Silence	1
Contemplative Walking/Hiking	3
Shamanism	1
Spending time with animals	1
Embodied practice (eg. dance, vigorous exercise)	2

Table 6

Ways That Spiritual Practice Supports Clinical Work

Themes from Qualitative Responses (responses can include more than one of the themes below)	n
Increases presence/sense of being grounded in present moment	12
Promotes self awareness	1
Helps maintain calmness during stressful situations	6
Restores balance of energy	2
Form of self-care	7
Helps keep work in larger perspective	9
Increases capacity for empathy	5
Supports acceptance	3
Reminder of purpose	3
Helps with letting go of pain/suffering involved in clinical work	3
Increases ability to support clients/patients who are spiritual	3
Source of personal support	9
Supports coping with client/patient loss	1

Table 6 outlines the main themes found in qualitative portions following “yes” responses to the question “do you feel that participation in your spiritual practice supports your clinical work with clients receiving palliative and/or end of life care?” 17 out of the 42 participants in the sample answered. As seen above, the theme with the most responses (12) was “increases presence/sense of being grounded in the present moment.” Themes “source of personal support” and “helps keep work in larger perspective” had the second most responses (9). Additional

themes that were significantly represented suggested that participants in the sample felt their spiritual practice acted as a source of self-care, supported them in staying calm during stressful moments, and increased their capacity to have empathy for clients/patients.

Descriptive Statistics for Hypotheses

This study attempted to test the following hypotheses: 1) Participation in spiritual practice would be negatively correlated with self-reported levels of compassion fatigue (CF). 2) Participation in spiritual practice would be positively correlated with self-reported levels of compassion satisfaction (CS). 3) Participation in spiritual practice acts as a protective factor against compassion fatigue and burnout for spiritual practitioners. As aforementioned, no statistically significant correlations were found in the data to validate the first two hypotheses related to spiritual practice and levels of CS/CF. The qualitative data presented in table 6 combined with the sample's ProQOL V scores presented in Table 2 suggest that participation in a spiritual practice may have supported a healthy balance of moderate to high CS, and low CF/BO in the sample. A control group of participants that do not identify as spiritual would be needed to statistically confirm this analysis. The following chapter will address the larger context of these findings and how they relate to the reviewed literature.

CHAPTER V

Discussion

This exploratory quantitative study intended to explore the following question: how is participation in spiritual practice related to self-reported levels of compassion fatigue and compassion satisfaction among mental health clinicians working with clients receiving end of life and/or palliative care (EOLPC)? This chapter will discuss findings presented in the previous chapter as they relate to themes found in the reviewed body of literature. Additionally, this chapter will discuss the study's limitations, strengths, implications for clinical practice in the EOLPC field, and recommendations for future research.

Participant Sample Characteristics

This study's sample reflected demographic trends in the EOLPC healthcare field and more specifically in the field of clinical social work. The majority of participants identified as White (90.7%) and female (94.4%). Additionally, almost every participant identified with the professional discipline of clinical social work. Clinical psychology (1.9%) and mental health counseling (1.9%) were the only other two disciplines represented in the sample. The prevalence of clinical social workers in the sample may be explained by the important role that social work plays in a variety of healthcare settings where EOLPC is offered.

The aforementioned demographic characteristics of the study sample are consistent with the data collected in a national workforce study (National Association of Social Workers, 2006) of over 10,000 licensed social workers. The National Association of Social Workers study

revealed that the field of social work is dominated by White (86%) clinicians who identify as female (National Association of Social Workers, 2006). Additionally, statistics on social workers in the healthcare and aging fields showed a majority of female identified clinicians (National Association of Social Workers, 2006). The demographic characteristics of this study's sample reflects the reality that mental health positions in the EOLPC field are mostly occupied by White, female-identified, clinical social workers (National Association of Social Workers, 2006). This reality undermined my attempts to recruit clinicians from other racial, ethnic, and gender identity groups. Additionally, it is important to note that participation in this study may have been less appealing for clinicians from marginalized populations because of the additional load of traumatic stress they may face due to systemic and interpersonal forms of oppression and violence.

Clinical practice environment was the most diverse demographic category in the sample. Participants in the two largest groups in the sample identified outpatient medical clinics (35.2%) and inpatient hospital units (25.6%) as their main clinical practice environments. Participants in the third and fourth groups identified patient homes and "other" practice settings as their main clinical practice environments and accounted for a combined 26% of the sample. The diversity of practice environments represented in the sample reflects the dynamic nature of social work practice as a whole and more specifically in healthcare and EOLPC settings. From a meta perspective, this diversity may also reflect the subtle ways that society is beginning to create space for end of life and palliative care issues and needs to be addressed. More research is needed to understand how social workers are being supported in providing EOLPC in the non-traditional settings that study participants cited such as private practice or cancer support organizations.

Compassion Fatigue, Compassion Satisfaction, and Burnout

Based on the literature reviewed, I hypothesized that compassion fatigue, burnout, and compassion satisfaction scores would be moderate to average in this study's sample of EOLPC clinicians. The data from the ProQOL V challenged this hypothesis to some extent. Overall, the sample of participants scored lower on each ProQOL V subscale (secondary traumatic stress, burnout, and compassion satisfaction) than average scores from the ProQOL database ($m=50$) (Stamm, 2010). This discussion section will focus specifically on the ProQOL scores as they relate to the literature and demographic characteristics. The role of spiritual practice in the larger context of this study will be discussed in the sections that follow.

Study participants scored extremely low on the secondary traumatic stress (STS) subscale ($m=18.03$). Most participants in the sample answered "never" or "rarely" to statements that measured secondary traumatic stress symptoms (eg. hyper vigilance, anxiety, fear, and disassociation). Burnout (BO) scores for the group were similarly low ($m=19.01$) and revealed that most participants answered "never" or "rarely" to statements intended to test for symptoms such as exhaustion, feelings of hopelessness, and feelings of apathy. The sample's mean CS score ($m=43.21$) indicated a moderate level of compassion satisfaction. The aforementioned data from the ProQOL V suggests that study participants as a whole had a positive relationship to their EOLPC clinical work with little to no feelings of being ineffective or overwhelmed by negative experiences in their professional lives (Stamm, 2010).

The absence of extreme highs in the sample's STS and BO scale scores reflected a particular quality of equanimity amongst participants. This equanimity is consistent with the assertion in the literature that compassion satisfaction and more specifically feelings of achievement, may act as a buffer and protect clinicians from feeling the negative impacts of

work related stressors (Figley, 2002; Stamm, 2002). EOLPC clinicians in the sample may have been insulated from the negative impacts of work stress and thus not reported them as robustly as a sample of participants with less compassion satisfaction. Specific data results from the sample's compassion satisfaction subscale imply that compassion satisfaction served this protective function for difficult aspects of participants' EOLPC clinical work. Results from the CS subscale revealed that 66.7% of participants received satisfaction "very often" from being able to work with people (Stamm, 2010). Similarly, a combined 82% of participants answered "very often" or "often" to the statement "I feel invigorated after working with those I help" (Stamm, 2010). 49 out of the 55 participants answered "very often or often" to the statement "I like my work as a clinician" (Stamm, 2010). This sampling of specific data from the CS subscale provides relevant context for the moderate ProQOL CS scores and highlights the feelings of satisfaction, pride, and invigoration amongst EOLPC clinicians in the study's sample.

When examined from a purely statistical perspective, the ProQOL V results for compassion fatigue and burnout may seem inconsistent with the findings aforementioned in studies that found a moderate to high prevalence of burnout and compassion fatigue symptoms amongst EOLPC professionals (Simon et al., 2006; Chan, Fong, Wong, Tse, Lau, & Chan, 2016; Sansó et al., 2015, Quinn-Lee et al, 2014, Whitebird et al., 2013, Perez et al., 2015). However, the sample's ProQOL V results for compassion satisfaction also reflect the theme of high job satisfaction found in other studies with EOLPC clinicians (Clark et al., 2007, Sanso et al, 2015). The sample's ProQOL V scores may be explained by numerous factors that were impossible to statistically analyze with quantitative methods, such as participation in types of spiritual practice, clinical practice environment, racial/ethnic identity, and gender identity.

In terms of gender and racial identity, the sample's scores are consistent with norms reported in the ProQOL database. Stamm (2010) asserted that no significant statistical differences in STS, CS, and BO scores had been found across male/female gender categories in the ProQOL database of studies. It is important to acknowledge that there has not been any data collected from studies that have used the ProQOL and included individuals that identify as transgender, genderqueer, or any other gender identity outside of the male/female binary. Significant statistical differences in STS and BO scores were found between non-Whites and Whites in the compiled data from ProQOL studies (Stamm, 2010). Whites reported less BO and STS than non-Whites (Stamm, 2010). This study sample's high percentage of White female identified participants did not allow for confirming these ProQOL norms, but must be considered as an important contextual variable.

The virtual nonexistence of BO and STS in the sample begs the question of appropriateness of the ProQOL V as a measure for research with this sample of EOLPC clinicians. When closely examined, the results of the STS and BO subscales showed that the majority of participants did not identify with statements that contained the word trauma or traumatic events. This may suggest that the participants' experiences did not match the ProQOL V's theoretical frame of secondary traumatic stress/compassion fatigue. It is possible that this particular sample of participants experienced other types of stress, such as death anxiety or grief, which the ProQOL V could not measure. It is also possible that clinicians who were suffering from high levels of compassion fatigue and or burnout may have not wanted to participate in the study. The following section will address how participation in spiritual practice relates to the sample's ProQOL V data.

Relationship Between Participation in Spiritual Practice, CF, CS, and BO

The discussion of this study sample's self-reported levels of compassion fatigue, compassion satisfaction, and burnout would be incomplete without addressing the fact that the overwhelming majority of participants (84.3%) identified as participating in a spiritual practice. The resulting small group of participants who did not report engaging in spiritual practice made it difficult to examine the differences between levels of STS, BO, and CS. With that said, the data found that participants who reported engagement in spiritual practice had lower mean burnout scores ($m=18.49$) than participants who did not report engagement in spiritual practice ($m=21.88$). This difference is noteworthy and suggests that participation in spiritual practice may support EOLPC clinicians in taking care of themselves, feeling connected in their work, and avoiding burnout.

Burnout's symptomology is generally thought of as being caused by systemic dysfunction and personal stress that leads clinicians to feel exhausted, apathetic, and disconnected in their work (Lee & Ashforth, 1990). Self-care strategies and appropriate professional support have been cited as the main ways to treat and prevent burnout (Killian, 2008; Quinn-Lee, Olson-McBride, & Unterberger, 2014; Harrison & Westwood, 2009). Participants cited ways that participation in spiritual practice "restores," "provides perspective," "replenishes empathy," "offers a refuge," and connects them to "their purpose" and the importance of their work. These themes are consistent with those cited in the reviewed literature on spiritual practice as an effective form of self-care (Cunningham, 2004; Rushton, Kasniak & Halifax, 2013; Rushton et al., 2009; Gregory, 2015). One participant affirmed the connection between their participation in spiritual practice and protection from burnout,

I feel that participating in my spiritual practice supports clinic work with clients. I feel I am better prepared to assist clients. I am able to show empathy. My spiritual practice helps me avoid burn out.

This quote highlights important themes of increased empathy, personal support, and effective clinical practice. The following sections will expand on themes found in the sample's qualitative responses.

Frequency and Types of Spiritual Practice Represented

Overall, the sample was made up of clinicians who participate in a spiritual practice at least once a week. Slightly less than half of the subsample of spiritual practitioners reported engaging in their spiritual practice daily. The data from qualitative findings revealed at least 16 different types of spiritual practices that participants engaged in. Prayer, attendance of religious services, and unspecified meditation practice were the most frequently cited spiritual practices in the sample. Prayer and meditation are two practices in particular that allow an individual to enter a contemplative space within. A sample participant described the impact of their meditation practice in the following response:

Meditation allows me the space to center and restore balance which allows me to be more present with my clients which is what is vital to any client you work with but particularly with clients in palliative or end of life care.

This response highlights the importance of creating space for centering and balancing that participation in prayer and meditation offered participants in the sample. These forms of practice may be particularly enticing for clinicians that are in professional roles that require high attunement, listening, speaking, and receiving constant input from chaotic healthcare environments.

EOLPC clinicians may also be drawn to these highly personal forms of spiritual practice because of their quality of intimacy. Prayer and meditation are two types of contemplative practices that have been found to foster a sense of intimacy with one's inner experience (Jacobs, 2015). Facing death and illness is arguably some of life's most intimate work. Thus, practices that create a safe and intimate space for processing emotion and encouraging self-reflection may also attract clinicians that are faced with unique existential issues in their work.

The second most cited spiritual practice was participation in religious services. Some participants specified attending "mass at church," "retreats," or "synagogue" as an aspect of their spiritual practice. Practicing in community was the main theme found in all of the responses that cited this form of practice. Many of the other qualitative responses included forms of practice such as engagement in spiritual community and religious study that fit this theme of practicing in community. These interpersonal forms of spiritual practice may also support EOLPC clinicians to socialize, connect, and foster meaningful relationships outside of their professional connections with patients and families. A participant expressed the connection between their spiritual practice, meaningful relationships, and empathy, "I feel that my spirituality allows me to replenish my feelings of empathy. When I am able to engage with people I love or take strength from positive interactions, it increases my capacity for empathy and patience." Clinicians who practice in spiritual community may have a greater capacity to separate from their work and connect with others that share their worldview. In turn, taking regular breaks from work may increase EOLPC clinician's ability to be present and empathetic with their patients and colleagues.

Impact of Spiritual Practice on Professional Work

The overwhelming majority of spiritual practitioners in the sample felt that their participation in spiritual practice supported their EOLPC work. Three main themes about spiritual practice and EOLPC work emerged from qualitative responses: increases presence/sense of being grounded in the present moment, source of personal support, helps keep work in larger perspective. The following participant responses highlight these themes:

My spiritual practice supports my clinical practice every day. I do not talk about beliefs or practices with either clients or staff, but most of them "know" or tell me that they can "tell" anyway. Meditation keeps me focused on the present, allows me to be fully present with my patients, keeps me "grounded" when things get turbulent at work. I could not do this work without this base.

It helps me feel connected to something bigger than me. It also helps me remain realistic about what I can control and what is beyond my control. It gives me a framework to do my best and to accept grace when I feel I have fallen short of my best.

The aforementioned quotes suggest that spiritual practice has a certain quality of necessity or indispensability for EOLPC work. This theme was echoed in particular by one participant who stated, "I don't know how people could be involved in palliative/supportive care, or cancer care in general without a spiritual practice or belief. It sustains me and helps me to prepare for difficult situations." The qualitative responses from participants paint a very clear picture that participation in spiritual practice is central to participants' self-care and effective EOLPC clinical work. More research is needed to include the experiences of EOLPC clinicians who do not participate in spiritual practices but have found alternative ways to foster feelings of joy and fulfillment in their work.

As a whole, this study sample's qualitative data fit well with the themes of increased self-awareness, support, calmness, and presence articulated throughout the literature (McGarrigle & Walsh, 2011, Gregory, 2015; Rushton et al., 2009). From a compassion fatigue theory perspective, participants with low STS and BO scores should have less empathy because empathy is the main predictor for compassion fatigue (Figley, 2002). The sample's moderate CS scores and qualitative responses that confirmed empathy as a crucial ingredient in sample participants' EOLPC work challenged compassion fatigue theory's main argument. Thus, Harrison and Westwood's (2009) theoretical construct of exquisite empathy best support this study's findings. Additionally, this study's findings are consistent with Buddhist theoretical understandings of compassion as a feeling that "does not fatigue, but rather replenishes us" (Kearney & Weininger, 2016, p. 132). These two frameworks may be ideal for understanding the unique ways that empathy and compassion impact EOLPC clinicians.

Strengths and Limitations of Present Study

Study Design. A major strength of the study design was the inclusive language used to define spiritual practice. This design feature resulted in a diverse understanding of spiritual practice being represented in the sample. As aforementioned in previous chapters, including the language "spiritual practice" may have attracted clinicians who identified as spiritual practitioners and dissuaded clinicians that did not identify as spiritual practitioners. Another strength of the study was the inclusion of open-ended questions. This aspect of the survey design allowed for qualitative themes to emerge that contributed to a deeper understanding of participants' understanding of their spiritual practice and professional life.

The electronic administration and recruitment of the survey were both significant limitations. An online platform may have not been ideal for clinicians who already spend many

hours of their workweek on a computer or answering e-mails. With that said, an online survey was a cost effective choice and allowed for expedited data collection to occur within the two months available for data collection. Ideally, future research should have a much larger time frame for data collection to increase the sample size and diversity. Future research should also include non-electronic recruitment strategies and offer a paper option for the survey.

Lastly, the study did not address any factors besides spiritual practice that might be related to levels of compassion fatigue, burnout, and compassion satisfaction. Thus, it was difficult to assess what other variables, such as age, levels of empathy, years in practice, and caseload, may have contributed to the sample data. Lastly, the scope of the study did not allow for inclusion of additional measurements of spiritual well-being or spiritual integration that could provide more data to explore the meaning of spiritual practice in the lives of EOLPC clinicians.

Sample. The aforementioned study design limitations greatly contributed to the study yielding a small (n=55) and homogenous sample. Despite recruitment efforts, clinicians of color were grossly underrepresented in the study. Similarly, clinicians that identified with gender categories other than "female" were not represented in any significant way. The fact that the sample was comprised mostly of clinical social workers that participate in a spiritual practice significantly affected the generalizability of findings. Additionally, the aforementioned lack of diversity in the sample prevented data analysis that may have led to additional understandings of how gender, race/ethnicity, professional discipline, and spiritual practice were correlated with CF, CS, and BO. Overall, the study privileged the narratives of a narrow sample of white, female identified, clinical social workers that participate in a variety of spiritual practices.

Implications for EOLPC Practice

The most significant qualitative data findings from this study suggest that participation in spiritual practice supported the professional work of EOLPC clinicians in the sample. These findings may be of benefit to other clinicians in the EOLPC field as well as their colleagues in IDT teams. Shedding light on how participation in spiritual practice impacts EOLPC workers may help educate healthcare and community mental health agencies about the connection between spiritual self-care and effective social work practice in EOLPC settings. Many of the ways that participants' spiritual practices supported EOLPC work, such as providing grounding and increasing presence, may be important skills to include in professional training programs and foundational educational classes for mental health clinicians in the EOLPC field.

Additionally, the findings from this research may benefit clinicians from other disciplines that are exposed to high levels of stress, grief, and trauma in their professional work. EOLPC clinicians are faced with the challenging task of navigating unique stressors related to being with death and illness. The spiritual tools cited by participant's may be of interest and support to other clinicians from other fields of social work practice who will have to face death or illness with a patient at some point in their careers. Additionally, some of the insights from participants in this study may help educate new clinicians who do not have as much experience navigating EOLPC issues in their practice.

Recommendations for Future Research

This research endeavor did not yield the expected statistical evidence of a relationship between participation in spiritual practice and self-reported compassion fatigue, compassion satisfaction, and burnout levels. Thus, future research is needed to assess if there is actually a correlation between these variables amongst EOLPC clinicians. The aforementioned findings

suggest that participation in spiritual practice may be a cornerstone for many clinicians in the EOLPC field, but existing research has not confirmed this in any meaningful way to date. Additionally, the lower than average levels of CF, CS, and BO in the sample suggest that there may be other theoretical frameworks and measurements that are more appropriate for researching stress related constructs with EOLPC clinicians. Ideally, research should also be conducted to determine what language is most effective for inspiring self-disclosure from clinicians about the "shadow" side of being in a helping profession.

Future research should include both quantitative and qualitative studies that closely examine the experiences of licensed clinical social workers working in the EOLPC field in a variety of settings. Quantitative methods, particularly studies that assess for levels of grief, spiritual beliefs, empathy, and presence, would be useful to determine the unique needs and coping strategies of clinicians in the EOLPC field. These types of studies could also be used to assess for differences and similarities in a variety of EOLPC practice environments. Qualitative methods such as in-depth interviews may be useful for revealing additional themes of suffering and resilience that could improve social work training and professional development in the EOLPC field. Overall, the lack of research in this budding field exposes the general attitudes of discomfort and anxiety that the research community may have towards examining topics related to end of life issues and the ways that death impacts professionals in the EOLPC field.

Conclusion

This study explored the twin emotions of joy and sorrow through the constructs of compassion fatigue and compassion satisfaction with a small sample of end of life and palliative care mental health clinicians. The findings of this study demonstrated that participants had lower than average levels of secondary traumatic stress and burnout. Participant levels of compassion

satisfaction were moderate and within average ranges. The majority of the sample identified as participating in various forms of frequent spiritual practice. Participants found that these forms of spiritual practice supported their EOLPC clinical work. The findings from this study indicate a need for further research that examines the ways that participation in spiritual practice impacts levels of empathy and compassion among the national workforce of EOLPC mental health clinicians.

EPILOGUE

Bird Wings

Your grief for what you've lost lifts a mirror up to
where you're bravely working.

Expecting the worst, you look, and instead,
here's the joyful face you've been wanting to see.

Your hand opens and closes and opens and closes.
If it were always a fist of always stretched open,
you would be paralyzed.

Your deepest presence is in every small contracting
and expanding,
the two as beautifully balance and coordinated
as birdwings.

—Rumi (1995)

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APPENDIX A:

Approval Letter from Human Subjects Review Board



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 3, 2016

Nathalie Rodriguez

Dear Nathalie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Tessa Hutchinson, Research Advisor

APPENDIX B:

Protocol Change Approval from Human Subjects Review Board



School for Social Work
Smith College
Northampton, Massachusetts
01063
T (413) 585-7950 F (413) 585-
7994

February 5, 2016

Nathalie Rodriguez

Dear Nathalie:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Tessa Hutchinson, Research Advisor

APPENDIX C:

Human Subjects Informed Consent Form

2015-2016

Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

.....
Title of Study: The Resilient Open Heart: Exploring Compassion Satisfaction, Compassion Fatigue, and Spiritual Practice With End of Life and Palliative Care Mental Health Clinicians

Investigator(s): Nathalie Rodriguez

.....
Dear Participant,

My name is Nathalie Rodriguez. I am a graduate student at the Smith School for Social Work and currently working as a medical social work intern on a palliative care interdisciplinary team.

My experience in the field has inspired me to conduct research centered on exploring the inner experiences of experienced clinicians working with clients that are facing chronic, life threatening, and terminal illnesses.

This research study will ask you to reflect on two main themes: How does your work bring you feelings of fulfillment and joy (*compassion satisfaction*)? How does your work negatively impact your own emotional, psychological, and physical wellbeing (*compassion fatigue*)? Lastly, this study will ask you to discuss if you participate in a *spiritual practice* (ways of connecting you to meaning, purpose, and/or the sacred). This aspect of the study is intended to explore if participation in spiritual practice is related to levels of reported compassion fatigue and compassion satisfaction.

Eligibility

- You were selected as a possible participant because you are:
 - 1) over 25 years of age
 - 2) literate in English
 - 3) a licensed master's level clinician in the field of clinical social work, counseling, or psychology
 - 4) have worked with patients receiving palliative care or hospice services for at least two years.
- I ask that you read this form before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to answer the following question: How does participation in spiritual practice relate to compassion fatigue/compassion satisfaction reporting amongst EOLPC clinicians?
- This study is being conducted as a research requirement for *my master's in social work degree*.

- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to participate in an anonymous 40 question online questionnaire.
- It should take you approximately 15-20 minutes to complete the survey.

Risks/Discomforts of Being in this Study

- This study poses minimal risks to participants. There is possibility that you might feel uncomfortable emotions or distress while completing a survey that will ask you to reflect on statements that are intended to measure the cost of working closely with individuals who are suffering/experiencing trauma. A list of mental health and educational resources is included at the end of this letter for you refer to as needed.

Benefits of Being in the Study

- You may benefit from the opportunity to reflect on feelings of fulfillment and satisfaction related to your work in the end of life and palliative care field.
- Reflecting on challenging feelings related to your work may offer you an opportunity to find ways to support your own wellbeing or inspire you to reach out for professional support.
- You may also benefit from knowing that you have contributed to research that could lead to a better understanding of compassion fatigue and compassion satisfaction amongst clinicians in this field.
- My hope is that this study will contribute research to validate the efforts being made by researchers, educators, spiritual communities, and non-profit organizations to support clinicians and their clients that are facing illness and death.

Confidentiality

- This study is anonymous. I will not be collecting or retaining any information about your identity.
- Your participation will be kept completely confidential. The survey software does not collect names, e-mail addresses, IP addresses, or any other identifying information. Any identifiable data from the open-ended questions in the survey will be stored in a password-protected location. Data will be shared with my research advisor only after any identifiable information has been removed. To ensure that your anonymity is protected, please do not include any identifying information about you, your clients, or your workplace in write in responses.
- Any future publications will present data as a whole and exclude any identifying information in brief vignettes or illustrative quotes.
- Any identifying information related to questions e-mailed about the survey (such as names/e-mail addresses) will be stored in a secure and password protected electronic location and not shared with anyone other than this researcher.
- All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

Payments/gift

- Due to the researcher's limited monetary resources as a student, you will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the researcher of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If you choose to participate, you may withdraw from the questionnaire at any point and you may choose not to answer any or all of the questions, by skipping them. Once you have submitted your data it will be impossible to withdraw from the study as your data is anonymous and I will be unable to identify your survey responses.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, by e-mail at xxxxxxxxx@gmail.com. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Sincerely,
Nathalie Rodriguez

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Referral Sources

- National Suicide Hotline: 1-800-784-2433
- Compassion Fatigue Awareness Project- a non-profit organization that offers information on compassion fatigue, including coping strategies and resources.
Website: <http://www.compassionfatigue.org/index.html>
- Professional Quality of Life- website that includes information on the scale used in this study, compassion fatigue, compassion satisfaction, and resources for addressing symptoms of compassion fatigue.
Website: http://www.proqol.org/Home_Page.php

Consent

BY CHECKING “I AGREE” BELOW, YOU ARE INDICATING THAT YOU AGREE TO VOLUNTEER AS A RESEARCH PARTICIPANT FOR THIS STUDY, HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. Please print a copy and save it for your records. (Drop box to select “I agree” or “I disagree”)

APPENDIX D:

Recruitment Letter

To Whom It May Concern,

My name is Nathalie Joyce Rodríguez, and I am a graduate student at the Smith College School for Social Work, currently doing my final clinical internship as a medical social work intern on a palliative care team. I am writing to your organization to ask for your help in completing my Master's thesis by helping me disseminate my research study (a brief user-friendly online survey) that seeks to explore how participation in spiritual practice relates to levels of compassion fatigue and compassion satisfaction amongst mental health clinicians working in the end of life/palliative care field.

Participating in my study is easy; all I ask is that participants fill out an online questionnaire. This study will not ask participants to disclose any personal details about their work with clients. The questionnaire consists of closed questions and open-ended questions to measure compassion satisfaction, compassion fatigue, and participation in spiritual practice. If you or someone you know is eligible to participate, an informed consent form will be presented to you as part of the online survey. Participants will not be asked for their signature, but only to check a box if they agree to participate.

Criteria for participation:

- 25 years of age or older
- able to read and write in English
- a licensed master's level clinician in the following fields: clinical social work, clinical psychology, marriage and family therapy, or mental health counseling
- have worked with clients receiving palliative care or hospice care for at least two years

*Participants DO NOT have to identify as having a spiritual practice to participate in my survey-
-all experiences and perspectives are needed!

If you meet criteria for participating, I encourage you to take part in my study. Participation is anonymous, so I will have no way of knowing whether or not you participated. If you do not meet criteria, I encourage you to please **forward this email** to any acquaintances or colleagues you know of who may be eligible to participate.

Please follow this link to the survey:

If you have any questions about my research or the nature of participation, please feel free to reply to this email (xxxxxxxxxx@gmail.com) or contact me at a later date. If you reply to this email, please be cautioned not to hit "Reply all."

Thank you for your time and interest in my research topic!

Sincerely,

Nathalie Joyce Rodríguez

MSW Candidate, Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

APPENDIX E:

Online Recruitment Posting

Dearest Facebook community members,

To complete my MSW program at Smith College School for Social Work, I am conducting a survey study that seeks to answer the following question:

How does having a spiritual practice relate to compassion fatigue and compassion satisfaction reporting in mental health clinicians working in the end of life/palliative care field?

This research is near and dear to my heart as an intern on a palliative care team. It may have the potential to positively impact education/training for mental health clinicians who are engaged in the brave and beautiful work of bearing witness to illness and death.

To be eligible to participate in my brief and anonymous online survey you must:

- be 25 years of age or older

- be able to read and write in English

- be a licensed master's level clinician in the following fields: clinical social work, clinical psychology, marriage and family therapy, or mental health counseling

- have worked with clients receiving palliative care or hospice care for at least two years

*You DO NOT have to identify as having a spiritual practice to participate in my survey--all experiences and perspectives are needed!

Click on the link below to participate:

Please re-post and share my survey with anyone you know that might be interested/eligible in participating.

Deep gratitude for all your support and interest!

Nathalie Joyce Rodriguez

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

APPENDIX F:

Online Questionnaire

Please respond to the following demographic questions.

I. Demographic Questions:

1. What is your professional discipline?

Clinical Social Work

Clinical Psychology

Mental Health Counseling

Marriage and Family Therapy

2. How do you identify racially/ethnically?

Black or African American

Hispanic, Latino, or Spanish origin

Asian

Middle Eastern

Native American or Alaskan Native Pacific Islander

Mixed Race or Biracial

White or Caucasian

Other (please specify) _____

I'd prefer not to answer

3. Please select the gender you most identify with:

Woman

Man

Transgender

Genderqueer

I'd prefer not to answer

Other (please specify) _____

4. In which of the following settings do you most often practice?

In-patient hospital unit

Outpatient medical clinic

Agency or community mental health center

Client homes (Home care agency)

Personal office space

Other (please specify) _____

II. Professional Quality of Life Scale Compassion Satisfaction and Compassion Fatigue Test

Below are some questions about your experiences, both positive and negative, as a clinician working in the EOLPC field. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1- Never 2- Rarely 3-Sometimes 4- Often 5- Very Often

1. I am happy.
2. I am preoccupied with more than one person I work with.
3. I get satisfaction from being able to work with people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my personal life from my life as a clinician.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I work with.
9. I think that I might have been affected by the traumatic stress of those I work with.
10. I feel trapped by my job as a clinician.
11. Because of my work, I have felt "on edge" about various things.
12. I like my work as a clinician.
13. I feel depressed because of the traumatic experiences of the people I work with.
14. I feel as though I am experiencing the trauma of someone I have worked with.

15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with clinical techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a clinician.
20. I have happy thoughts and feelings about those I work with and how I could help them.
21. I feel overwhelmed because my case work load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I work with.
24. I am proud of what I can do to help.
25. As a result of my work I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a clinician.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

© B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. /www.isu.edu/~bhstamm or www.proqol.org.

III. Questions about Spiritual Practice

1. Do you participate in a spiritual practice (defined as a recurrent activity that you engage in to experience meaning, purpose, and your connectedness to the moment, self, others, nature, the significant, and/or sacred)?
Yes (proceed to next set of questions)
No (complete survey)

2. Please describe your spiritual practice in detail.

3. How often do you participate in your spiritual practice?

More than once a day

Daily

Weekly

Monthly

Other (please specify) _____

4. Do you feel that participation in your spiritual practice supports your clinical work with clients receiving palliative and/or end of life care?

Yes, please describe how

No, please describe what does support your work